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# **Child welfare inequalities: new evidence, further questions**

Paul Bywaters, Geraldine Brady, Tim Sparks, Elizabeth Bos

## **Abstract**

Research internationally has identified large differences in rates of child safeguarding interventions, recently characterised as child welfare inequalities, markers of social inequalities in childhood with parallels to inequalities in health and education. This paper reports a Nuffield Foundation funded study to examine the role of deprivation in explaining differences in key children's services' interventions between and within local authorities (LAs). The study involved analysis of descriptive data on over 10% of children on child protection plans or in out-of-home care in 14 English LAs at 31.3.12. The data demonstrates very large inequalities in rates of child welfare interventions within and between LAs, systematically related to levels of deprivation. There is evidence of a gradient in child welfare inequalities across the whole of society. There also appears to be an equivalent of the inverse care law for health: for any given level of deprivation in local neighbourhoods, LAs with lower overall levels of deprivation were intervening more often. The findings raise fundamental questions for research, policy and practice including whether the allocation of children's services resources sufficiently recognise the impact of deprivation on demand and how we judge whether a safeguarding system is effective at the population level.

## **Keywords**

Child protection, child welfare, inequalities, deprivation, looked after children, health

## Child welfare inequalities: new evidence, further questions

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### Introduction

A previous paper argued that major gaps in knowledge and understanding of child welfare services are revealed by an examination of the very large geographical variations in the proportion of children in out-of-home public care or subjects of child protection interventions (Bywaters, 2013).

On average, a child in economically disadvantaged cities like Hull, Manchester or Blackpool in England has a six to eight times greater chance of being on a child protection plan (CPP) or being looked after in out-of-home public care (LAC), than a child in affluent Wokingham or Richmond Upon Thames (Department for Education, 2013a, 2013b). Analysis of published data on these child welfare interventions shows strong and statistically significant correlations at the local authority (LA) level between measures of deprivation and rates of LAC and CPP, with regression analysis showing that over 50% of the variance in LAC rates is explained by deprivation scores (Bywaters, 2013). Similar large inequalities in children's chances of being subject to state safeguarding interventions are found internationally (Franzen et al., 2008; O'Donnell et al., 2008; Gilbert et al., 2012). This relationship is, of course, not a new discovery. Previous studies over more than 25 years (for example, Bebbington and Miles, 1989; Oliver et al., 2001; Sidebotham et al., 2002; Dickens et al., 2007) identified relative deprivation as the major factor influencing rates of CPP and LAC in England. However, this broad finding has been under-developed in research, policy and practice. The 11 studies in the recent Department for Education's Safeguarding Children Research Initiative focused on identification and initial response, intervention and inter-agency working. None examined causation or primary prevention.

We believe that improving the outcomes of child safeguarding requires some rebalancing of attention from individual cases to populations and systems. We are not alone in this. Different aspects of child safeguarding systems have come under close scrutiny in recent times. For example,

the Munro Review of Child Protection (2011, 6) concentrated on the question, “what helps professionals make the best judgments they can to protect a vulnerable child?”. The Association of Directors of Children’s Services’ (ADCS) examination of ‘Safeguarding Pressures’ (2012) focused on the significant increase in demand for children’s services since 2007/8 against a background of intensified budgetary constraints following the global financial crisis and other factors affecting safeguarding systems. The House of Commons Education Committee report on child protection (2012) emphasised identification of, and early help available for, children at risk of abuse and exploitation, and systemic aspects affecting decision making, thresholds for intervention and integrated processes. However, none of these reviews considered the underlying question: why are powerful state interventions in family life, such as placing a child on a CPP or in out-of-home care, required? Which children, in which places, are becoming ‘vulnerable’ and why? What are the structural causes of children’s involvement with state welfare services?

Three key points can be made about these gaps in knowledge and understanding. First, there is a lack of detailed *evidence* about the relationship between rates of children’s services’ interventions and the material circumstances of families whose children are LAC or on CPPs: the social, economic and environmental context in which they live (Simkiss et al., 2012). This contrasts with a range of studies which focus on identifying children at risk and the characteristics of their parents, such as high rates of domestic violence, mental ill-health and substance misuse (for example, Cleaver et al., 2010; Taylor et al., 2011; Wade et al., 2011; Ward et al., 2012). Second, there is insufficient *theorising* about the relationship between deprivation and rates of children’s services interventions (Hearn, 2011). Not enough attention has been given to developing explanatory models linking deprivation with intervention rates, models which could form the basis both of further research and the development of policy and practice. Third, there has been a reluctance to describe the relationship between deprivation and intervention rates as a matter of social inequality (Bywaters, 2013). Consequently, there is limited discussion of interventions aimed at reducing socially patterned inequalities in CPP and LAC rates. Recommendations from previous inquiries into

‘variations’ in rates tend to concentrate on creating greater consistency and uniformity in the policies and practices of children’s services agencies (Oliver et al., 2001; Dickens et al., 2007, Cordis Bright, 2013), a valuable aim in its own right but a different and, arguably, secondary issue to primary prevention. For each of these three points, the contrast with the study of inequalities in health is stark. For health inequalities there is an extensive detailed body of evidence exploring a variety of alternative theoretical models and a range of policy and practice applications (for example, Marmot, 2010).

This paper describes research that begins to address at least one aspect of these gaps in evidence and explanation internationally by providing a more detailed analysis of the extent and nature of inequalities in rates of CPP and LAC in England. The aim of the study, funded by the Nuffield Foundation, is to examine the role of deprivation in explaining differences in key children’s services’ interventions between *and within* LAs. Its objectives are, first, to relate core markers of safeguarding processes (CPP and LAC rates) to Index of Multiple Deprivation (IMD) scores for small areas within LAs; second, to begin to explore the implications of the analysis for the allocation of resources, workforce skills and intervention strategies and, third, to design a programme of subsequent studies to explore these issues further. This paper reports on the first objective.

The central focus of the project was to build understanding of child welfare inequalities - ‘unequal chances, experiences and outcomes of child welfare that are systematically associated with social advantage/disadvantage’ (Bywaters, 2013, p.4) - by examining differences in rates between small neighbourhoods within LAs, known as ‘lower layer super output areas’ (LSOAs). Output areas (OAs) came into use for official statistics with the 2001 Census and are constructed from postcodes to produce areas of similar population size (see <http://www.ons.gov.uk/ons/guide-method/census/census-2001/data-and-products/output-geography/output-areas/index.html>). OAs can be aggregated to produce LSOAs which have an average population of 1500 or middle layer super output areas (MSOAs) with average populations of 7500 (Office for National Statistics, 2012).

The key research objective explored in this paper is: ‘to what extent are children’s services’ ‘clients’ clustered in areas of greatest deprivation’?

Data about many aspects of children’s lives, their education and health and the environments in which they live, demonstrate a gradient in outcomes related to their socio-economic position (<http://www.cpag.org.uk/content/impact-poverty>). The concept of a socially determined gradient has been prevalent in discussions of inequalities in health for over forty years (Tudor Hart, 1971). It has been important for a number of reasons. First, socially determined inequalities in health affect people across the whole of society. Inequalities do not only affect the least advantaged and cannot be explained solely in terms of the behaviours of sub-groups within society. Second, the steepness of the gradient reflects the degree of inequality in health between people at different points on the socio-economic scale. Third, improvements in average population health can go hand in hand with growing inequalities. Therefore, fourth, if policies are to reduce inequalities in health, attention has to be paid to the gradient, not just to average outcomes, and must encompass consideration of the whole of society not just target attention on the least advantaged. This kind of thinking has been largely absent from social work discussion of child welfare systems internationally. There has been a tendency to focus on poverty rather than inequality (Jonson-Reid et al., 2009). We have not investigated whether there is a gradient in key markers of child welfare such as CPP and LAC rates or whether such interventions are largely confined to the most disadvantaged children. If there is a gradient we do not know how steep it is, how it is mediated by aspects of identity such as gender, ethnicity or disability or whether there is evidence of an ‘inverse care law’ (Tudor Hart, 1971) in the provision of children’s services. In the absence of such knowledge, constructing policies to address the fundamental causes (Phelan et al., 2010) of children’s vulnerability is difficult, to say the least.

## Methods

The study plan was to analyse data routinely collected by local authorities about children who were on a CPP or were LAC at 31<sup>st</sup> March 2012 to examine the relationship between rates of intervention

and deprivation scores. LAs in England with statutory children's services responsibilities report annually to the Department for Education key data about each child in need (CIN), on a CPP or who are LAC on March 31<sup>st</sup>. Children in need are essentially all the children with whom a given LA children's services department is working, although some care leavers may be 18 or over. All CPP and LAC are also CIN for this purpose, but CPP and LAC status are mutually exclusive for all but a few cases. Mid-year population estimates are used to calculate CIN, CPP and LAC rates per 10,000 children. These data are published for England, for regions and individual LAs. For this study, participating LAs were asked to provide the following anonymised data for each child: age or date of birth, gender, ethnicity, whether disabled or not, reason for being on a CPP, legal status if LAC and whether they were unaccompanied asylum seekers. The definitions used were those provided for the national returns: the guidance notes for the CIN Census 2011-12

(<http://media.education.gov.uk/assets/files/pdf/2/2011%2012%20cin%20census%20guidance.pdf>)

and the SSDA903 return for LAC

(<http://media.education.gov.uk/assets/files/pdf/s/ssda903%20guidance%20notes%202011-12.pdf>).

In addition, the location of the child's family home was requested in the form of the neighbourhood (LSOA) in which they lived. In the case of LAC, the LSOA from which they entered care was requested, not where the child was currently living. In addition, one interview was planned with a senior manager in participating LAs to put the statistical findings in context. An Advisory Group was recruited to advise on research processes, interpretation of findings and dissemination.

## **Ethical Issues**

Ethical approval was given by the ADCS Research Group and Coventry University's Research Ethics process. Under the ADCS Research protocol no further governance approvals were required by individual LAs. Interview participants gave informed consent.

One concern raised by the ADCS Research Group was that individual children might be identifiable because of the small size of LSOAs. Unprocessed data have been stored in a secure, password

protected, electronic location, accessible only by the one member of the research team responsible for the initial handing of data. All data were analysed only after aggregation by LSOA or MSOA. No analysis or research reports give any details of individuals.

### **The Sample**

For reasons including ease and speed of access, participating LAs were recruited primarily from the West Midlands region. All 14 West Midlands LAs agreed to take part in the study. Since these LAs have a slightly higher average level of deprivation than England as a whole, we approached two relatively advantaged LAs in the East Midlands region to generate a more representative sample. In the event, Rutland agreed to participate but the second LA did not. The inclusion of Rutland, while welcome, provided only a limited correction because it is a small LA with only about 30 LAC in March 2012. In addition, one West Midlands LA proved unable to provide data in the timescale requested.

At 31<sup>st</sup> March 2012, 10.5% (n = 1,187,320) of all children in England aged 0-17 lived in the 14 sample LAs, 11.6% (n = 4963) of all CPP and 12.4% (n = 8295) of all LAC. CPP and LAC rates were slightly higher than the national average, reflecting the deprivation profile of the sample. The LAs exhibited a wide range of CPP and LAC rates and deprivation scores, across a mixed economy of industrialised metropolitan boroughs and rural counties.

### **Data Cleaning Issues**

We encountered a series of issues in checking the data for accuracy. Our data request was made approximately a year after the LAs had submitted their online national returns. Since then, some data had been corrected and in one LA this had led to a reduction of CIN numbers of around 3000 cases. We assessed the data received against that published, and LAs were asked to check and explain any differences when numbers varied by more than 2%. CPP and LAC numbers, once checked, were within 2.5% of published data. It is impossible to say whether the published data or our sample can be viewed as a more accurate account.



A second set of issues emerged when we matched the LSOAs submitted against the LSOAs revised for the 2011 Census. Some LAs provided their returns using 2011 LSOAs; others were based on the previous boundaries established in 2001. Changes affected 2.6% of LSOAs nationally.

There were four sets of data that we had to reconcile:

- Published CIN, CPP and LAC data, using mid-year population estimates based on the 2011 Census.
- CIN, CPP and LAC data submitted by LAs, some using 2001 and some 2011 LSOAs.
- Population data for 2011 LSOAs based on the 2011 Census.
- 2010 Index of Multiple Deprivation data based on LSOAs from 2001.

Our analysis is based on 2011 LSOA boundaries and 2011 Census data for population, converting IMD scores and LA data to 2011 geographies as necessary. This corresponded to 3317 LSOAs in total with an average child (age 0-17) population of 358 per LSOA.

Four other factors reduced the numbers of children included in the final analysis.

First, 5.3% of children had no recorded LSOA. The majority of these were CIN. Some children had no home address to record: for example, Solihull has been a regional centre for Unaccompanied Asylum Seekers and so had a relatively large number – over 300 - CIN for whom there was no UK home address of origin. Children without LSOAs were not included in the analysis.

Second, some of the LSOAs were outside the LA reporting the data. This led to a further check to ensure we had not been given LAC placement addresses rather than home addresses of origin. Our analysis only includes those children with addresses within our 14 sample LAs.

Third, for some children, the date of birth was not given or unknown. In most cases, these were unborn children about whom child protection concerns had already been raised. These 542 children (1.6%) have been excluded from the analysis.

Finally, 111 cases appeared to be duplicates, mostly from a single LA. We assumed these resulted from recording errors and excluded them.

The result of these measures is that our sample included 91.3% of the published number of children on protection plans, 86.9% of published LAC and 91.9% of CIN aged 0-17. As stated above, it is unclear from our study which set of data – sample or published data – is more accurate. The extent of data cleaning that we had to undertake raises some questions about the consistency and accuracy of returns to the Department of Education which carries out its own checks before publishing the annual tables. However, this is an issue for a separate project.

The discussion above indicates the main difficulties we had in ensuring that the data were consistent with national guidance, between LAs and with published data. We have reported these at some length both so that readers can judge our findings and as an aid to subsequent research which we hope will replicate and extend our analysis. Further details are available at

<http://www.coventry.ac.uk/child-welfare-inequalities> .

Where does this leave the accuracy and representativeness of the sample? Overall, after corrections and eliminating cases which fell outside our study criteria, our analysis included over 9 in 10 of published CIN and CPP and 7 in 8 of LAC. The cases we eliminated, mainly because of lack of data on age or location, addresses outside the LA and duplication, mean the numbers and rates reported in our findings are lower than those published. The ‘corrections’ affected all LAs to some degree and, in the main, our findings should be read as indicators of the *relative* positions of LSOAs in the sample LAs, rather than of absolute numbers and rates.

### **Population Data**

The published national statistics on CIN, CPP and LAC use mid-year population estimates derived (for 2011-12) from the 2011 Census to calculate rates per 10,000 children. Because we needed to analyse children’s services activity for small neighbourhoods, only the Census itself could provide all of the necessary detail at LA, MSOA and LSOA levels.

## Deprivation Measures

Index of Multiple Deprivation (IMD) scores are derived from data about 7 domains of deprivation.

Thirty eight indicators produce measures in the 7 domains and are weighted to produce a single score reflecting 'the experience of the people in an area (that) gives the area its deprivation characteristics' (Department for Communities and Local Government (DCLG), 2011, p.11). The domains are:

- Income deprivation.
- Employment deprivation.
- Health deprivation and disability.
- Education, skills and training deprivation.
- Barriers to housing and services.
- Crime.
- Living environment deprivation.

The IMD has been the most widely used and respected measure of deprivation linked to local geographies in England. However, three limitations are apparent. First, the information on which the IMD 2010 is based is drawn from 2007 and 2008, mostly from before the impact of the global financial crisis. Second, IMD scores are available at LSOA but not MSOA level, while census data on ethnicity by year of age is only available at MSOA level and above. Third, the IMD is based on 2001 LSOAs so it has been necessary to reconcile the data with the 2011 boundaries using official conversion tables.

There are competing arguments for alternative measures of deprivation, all of which have drawbacks. It would be valuable if there were a measure drawing on more recent data, more clearly related to childhood wellbeing and capable of international comparison.

## Data Analysis Strategy

There were three main foci of our analysis: the existence and extent of differences between and within LAs in patterns of CPP and LAC; whether such differences were statistically significant and identifying whether significant differences were explained by deprivation.

The quantitative data were analysed using Minitab v16 software. National IMD scores based on 2001 LSOAs were converted to 2011 LSOAs by simple averaging for merged LSOAs or by allocation of original scores to split LSOAs. IMDs for all national LSOAs were then ranked and divided into 10 equally sized groups with 1 being the least deprived and 10 the most deprived. It is worth emphasising that these deciles represent national levels of deprivation, not local levels. For example, in the charts and tables below presenting our sample data, decile 10 refers to all sample LSOAs that are amongst the most deprived 10% of LSOAs nationally. Decile 10 does not refer to the 10% most deprived LSOAs *in the sample*, but the LSOAs in our sample that are in the most deprived LSOAs *in England as a whole*.

## Findings

The findings presented here are structured in terms of three key patterns found for inequalities in health: large differences in markers of health significantly related to deprivation, a gradient in health chances across whole societies rather than a gap between wealthy and poor populations and an inverse care law which says that the availability of health services is in an inverse relationship to need (Marmot, 2010; Watt, 2013). Do these well established relationships for health inequalities also apply to markers of child welfare inequalities?

### High levels of inequality

LSOAs in the sample LAs were over-represented amongst most deprived two deciles of LSOAs nationally and under-represented amongst least deprived (Table 1). Furthermore, high levels of

childhood poverty in England are reflected in the over-representation of children *within* the most deprived LSOAs: 16.6% of sample LSOAs were in the most deprived 10% nationally but 21.5% of sample children. The combination of an over-representation of deprived neighbourhoods and the over-representation of children within those neighbourhoods meant that 36.2% of all children in our sample were living in neighbourhoods amongst the most deprived 20% nationally, but only 12.7% in the most advantaged 20%.

Insert Table 1

The distribution of the child population differs starkly between LAs. For example, 49% of all Birmingham children were living in the most deprived 10% of neighbourhoods nationally, compared to only 1% in Herefordshire and 2% in Staffordshire. Twenty nine per cent of Solihull's children lived in the most advantaged decile of LSOAs nationally, but no child in Sandwell or Wolverhampton. LAs can have very similar overall IMD scores but very different distributions of children. Thirty nine per cent of Solihull children lived in LSOAs in the most affluent 20% nationally and 20% in the most deprived 20%. By contrast, in Herefordshire, with a very similar overall IMD score, only 5% of children lived in the most affluent quintile of LSOAs and 8% in the most disadvantaged.

Such differences impact powerfully on relative demand for children's services and reinforce the case for analysing patterns of child welfare interventions *within* as well as between LAs. This is illustrated in Charts 1 and 2 showing the distribution of children on CPPs and LAC across the ten deciles by deprivation. There was a very strong relationship between the deprivation decile and the *numbers* of children who were CPP or LAC. As a result, there were 40 times more LAC and 36 times more children on CPPs from families living in the most deprived decile of neighbourhoods compared to the least deprived decile.

Insert Charts 1 and 2

More importantly, in some respects, *rates* of CPP and LAC (Charts 3 and 4) also showed large differences and consistent increases with rising levels of disadvantage. A child's chances of being on a CPP was 10 times higher in the most deprived 10% of LSOAs compared to the least deprived decile and over 11 times higher for LAC.

Insert Charts 3 and 4

This relationship between intervention rates and deprivation holds true also for each individual LA. For each LA other than Rutland (with very small numbers), as well as overall, the correlation between neighbourhood deprivation decile scores and these two forms of child welfare intervention is strong and statistically significant ( $p < 0.001$ ). The differences in rates between LAs and between neighbourhoods are not a post-code lottery, nor are they simply the result of random differences in LAs policies and practice; they are markers of social inequalities.

### **A gradient in children's chances**

Although Charts 3 and 4 demonstrate large differences in CPP and LAC rates by deprivation, these interventions are not concentrated only in disadvantaged neighbourhoods. Indeed, the concentration was less apparent than we had expected. A little over 60% of CPP and LAC in our sample came from the most deprived 20% of neighbourhoods where 36% of children lived. But this means that just under 40% of children on CPPs and LAC were amongst the 64% of children living outside the most deprived 20% of neighbourhoods. It was not only between the extremes of affluence and deprivation that an inequality in rates could be seen: each step increase in deprivation level was accompanied by an increase in rates of CPP and LAC. The only exception was between deciles 3 and 4 for CPP, where numbers are relatively small. There is a social gradient in child welfare intervention rates across the whole of society, just as there is a gradient in health (Marmot, 2010).

Our data do not allow us to explain the existence or the steepness of these gradients beyond the general impact of deprivation. For that we would need information about the circumstances of individual families. Such evidence would be a valuable adjunct to this analysis, but is not available.

It is possible that the concentration of extreme interventions on relatively deprived *families* might be greater than the concentration on deprived *neighbourhoods*. Some families facing particularly difficult circumstances may be living in neighbourhoods which in general are relatively affluent. Indeed, it was suggested to us by senior managers that not only that this might be the case but that disadvantaged families might stand out in more advantaged neighbourhoods and be more likely to become the subject of referrals and interventions than if they were living among equally deprived families in more deprived neighbourhoods. Another possibility is that the way that standards and thresholds are applied varies between areas so the spread of intervention rates is an artefact of policy and practice. For this to explain the patterns seen would require that children's services were systematically more likely to intervene in more affluent than less affluent areas, an issue we consider below, but which this study was not designed to test.

The data are also entirely compatible with the evidence that there is a social gradient in a wide variety of crucial dimensions of childhood with important consequences for their trajectories in adult life. All families face pressures from time to time and have greater or fewer resources and resilience to deal with those pressures (Hooper et al., 2007). Some families from any neighbourhood may face difficulties that may result in children's services interventions. But families in greater deprivation face greater pressures and they and the neighbourhoods in which they live may have fewer resources and less resilience, what some might call less social capital. But this explanatory model, while compatible with our data, cannot be tested by it.

### **An inverse intervention law in children's services**

In addition to the relationship between rates and deprivation shown above there are large variations between individual LAs as previous studies have discussed (for example, Dickens et al., 2007). The LA with the highest IMD score has by no means the highest LAC rate, and the LA with the highest LAC rate has by no means the highest IMD score, as Chart 5 illustrates. Different LAs appear to operate very differently. It was explaining such 'outlying' LA performances by reference to technical,

situational, interpretive and operational factors, in addition to taken for granted differences due to deprivation, that was the focus of Oliver et al.'s analysis (2001, p.5).

Insert Chart 5

However, our data suggest that these apparent policy and practice differences may themselves be patterned by relative deprivation. Our data show that intervention rates vary widely between LAs for neighbourhoods *at the same level of deprivation*. For example, in Herefordshire (IMD score 17.91) children living in the most deprived 10% of neighbourhoods nationally had a CPP rate of 238 per 10,000; children living in equally deprived neighbourhoods in Sandwell (IMD score 36.97) had a rate of 50, while for the LA as a whole their published CPP rates were both in the low 40s. At first glance this appears to contradict the suggested strong relationship between deprivation and rates of intervention. However, further investigation indicates the possible existence of an 'inverse intervention law' for child welfare services, similar to Tudor Hart's (1971) inverse care law for health services.

For any equivalent decile of deprivation in local neighbourhoods, LAs with low *overall* deprivation scores were intervening more often using CPPs or taking children into care than LAs with higher deprivation scores. So, for example, children in the most disadvantaged 10% of neighbourhoods nationally were more likely to be LAC or on a CPP if the LA overall was more affluent (see, for example, Chart 6). This did not apply only at the 10th decile but across the board (Table 5). There was a strong negative correlation between overall LA IMD scores and rates of CPP and LAC at each decile by deprivation for all but 1 of 20 cells. Many of these negative correlations were statistically significant, at least at the  $p \leq 0.05$  level, even though there were only 13 pairs of values to test for significance (Rutland excluded because of low numbers). This suggests that the inequalities in rates between LAs for any given level of deprivation were not just a post code lottery for children, nor just the product of differences in local priorities, policies and practice, but systematically, inversely, related to deprivation. Of course, this clear statistical relationship does not explain all the variance.



Insert Chart 6

Again, further data would be needed to explain this but at least three main possibilities might be explored. First, differences in practice and policy: as speculated above there might be lower tolerance of family difficulties affecting children (lower thresholds) in areas of generally greater affluence. This might reflect higher staff morale or greater experience in areas of greater advantage which might lead to more assertive interventions. In any case, one would want to ask why this would result in higher rates of CPP and LAC rather than more effective preventive interventions.

The second possibility is that differences in population patterns between LAs, particularly in the proportion of children from different ethnic groups, compounded by inequalities in rates of CPP and LAC between ethnic groups, combine to create the inverse intervention rates. We will be examining this possibility in a future paper.

The third possibility is that more advantaged LAs have more resources relative to the level of demand than the more deprived LAs: they intervene more often because they have more capacity to do so. This is not to say that resources are excessive or even sufficient in any LA. Preliminary work on children's services' budgets using the Section 251 Financial Data Collection records, available from the Department of Education online, at least raises the question whether deprivation is adequately taken into account in the allocation of central government budgets to LAs. However, children's services budgets are highly complex and more work is required to explore the reasons for this apparent inverse relationship.

### **Conclusion: Implications for practice, policy and research**

This is one study, in one year, of around 1 in 10 LAs in England, drawn exclusively from one region of one country. As outlined earlier, there were difficulties in precisely reconciling the sample data with published data, as previous studies have also found (Oliver et al., 2001), and the dataset analysed represents about 90% of the published numbers of CPP and LAC in the sample LAs. It is important for

the work to be replicated and extended to include other geographical areas in England, other countries and trends over time. We ourselves have further analysis to conduct on our data to examine, in particular, the relationship between different dimensions of identity – age, gender, ethnicity and disability – and inequalities in rates of intervention within and between LAs.

However, our findings, based on over 10% of children on CPPs and LAC in England, are consistent with previous work on child welfare systems internationally which has pointed to substantial inequalities in rates of state intervention in family life between areas and population groups linked to relative deprivation. It is also consistent with studies of childhood inequalities focusing on health or education and with studies of inequalities in health affecting adults.

Three main conclusions emerge from this initial analysis of our data. First, we have found strong evidence that gross inequalities in children's life chances are being acted out through child welfare services. In the 1% most deprived LSOAs in the English midlands around one child in 35 is on a CPP and one in 25 is in out-of-home care at any point in time. But the focus of this paper is not on identifying individual children or their families but on the implications of patterns that are apparent across populations: the systematic link between levels of deprivation and a family's chances of being the object of powerful state interventions.

Second, the evidence of a child welfare gradient across society, paralleling the gradients in health and educational chances in a very unequal country (Wolfe, 2013), means that neither safeguarding children nor reducing inequalities in child welfare can be achieved by focusing only on the most deprived neighbourhoods. Rather, as Marmot (2010, 16) argues for health

To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Greater intensity of action is likely to be needed for those with

greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem.

Third, it appears that there is an equivalent of the inverse care law: that more advantaged LAs employ proportionately more, often substantially more, 'heavy end' interventions than relatively disadvantaged LAs for an equivalent level of deprivation. Our data could not report on preventive interventions. We are not implying that the inverse intervention evidence explains all the variation between LAs. Local cultures, policies and practice are also important. However, what have previously been assumed to be just local variations after deprivation is taken into account have been shown themselves to be, in part, related to deprivation. More work is required on the relationship between deprivation and the allocation of central government resources to LAs and between areas within LAs.

These findings raise fundamental questions about the child welfare system in England. Although some argue that children's services should be removing children from their families earlier and more frequently (Forrester 2009), there must be a danger that current pressures are resulting in more investigations rather than greater safety for children (Bilson et al., 2013; Lonne et al., 2013).

Between 2007/8 and 2012/13, the numbers of children starting CPPs in a year increased by 122%. But we do not know whether, overall, children are safer as a result, particularly if the cost of more investigations reduces funds for family support services. If more advantaged LAs are intervening more frequently in families for any given level of deprivation, is that making children safer, their development more secure and their long term futures more assured (Dickens et al., 2007)? If more advantaged LAs are using CPP and LAC interventions more frequently because they have relatively more resources, are they getting the right balance between protection and prevention? Are the most disadvantaged LAs with low rates at each decile intervening too little because of insufficient resources? If you are a child in one of the most deprived 10% of neighbourhoods, is it right that you should have an 11 times greater chance of being in care than a child living in a nearby affluent

neighbourhood? How do we judge whether a safeguarding system is increasing effectiveness by intervening in the lives of more children or less children (Dickens et al., 2007; Tilbury and Thoburn, 2009)?

Our data shines a light on inequalities in the child welfare system but was not designed to explain them. Nor can it answer whether child welfare interventions merely reflect or actively reinforce social inequalities. There is an urgent need for further research to fill the evidence gap, to test explanatory models and examine the impact of interventions on child welfare inequalities.

State intervention to protect children will sometimes be necessary. But reducing inequalities in CPP and LAC rates by reducing social inequalities overall, as the Commission on the Social Determinants of Health (WHO, 2008) has recommended, or by breaking the link between deprivation and extreme interventions by promoting good child development, could become a central goal of policy and practice, as it is for health and education.

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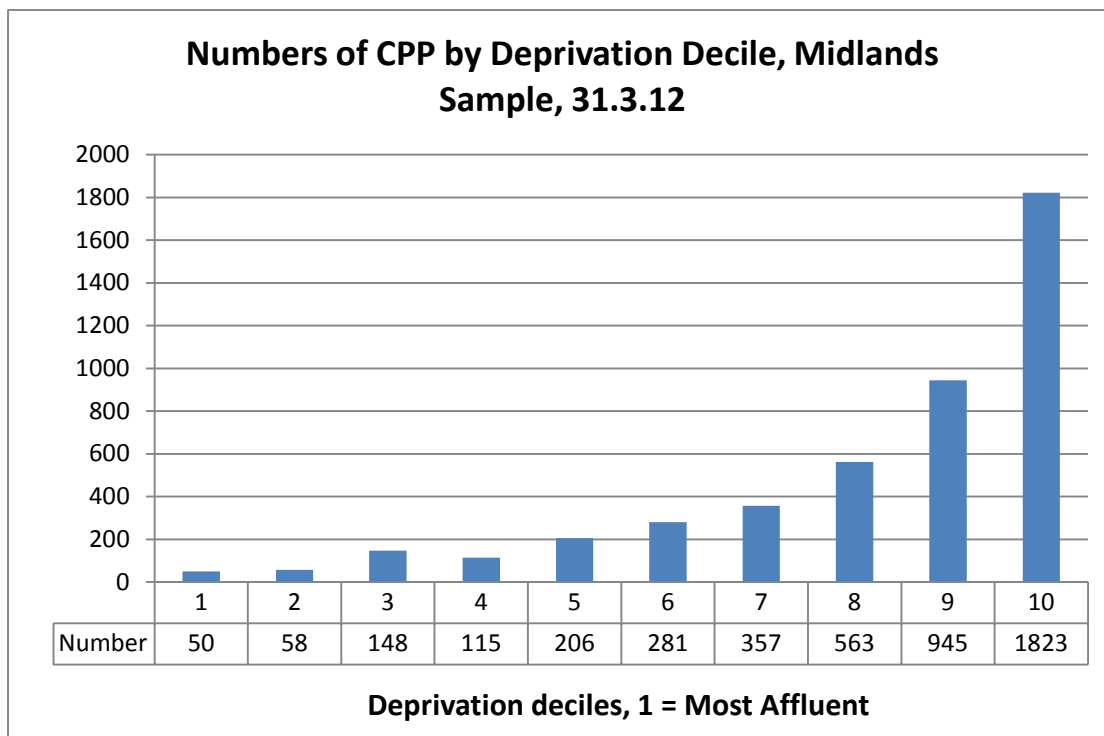
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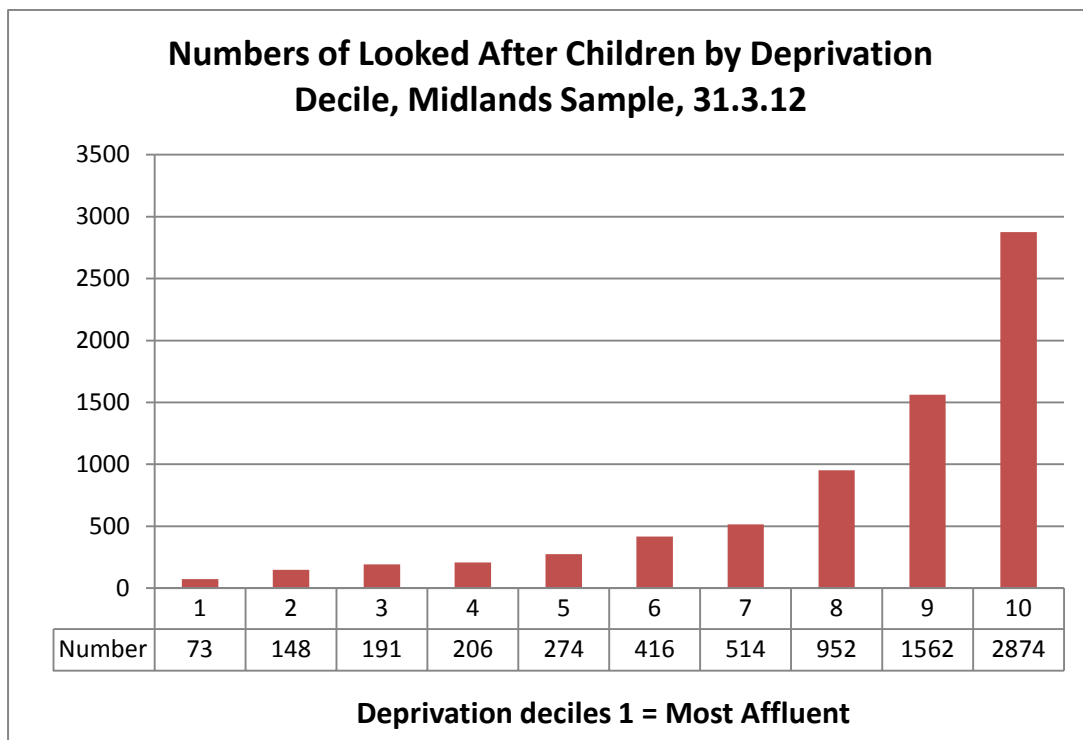
Table 1: Distribution of sample LSOAs and children by national deprivation (IMD) decile.

IMD Decile	Sample LSOAs: Percent	Sample Child Population: Percent
1	7.3	6.4
2	7.3	6.3
3	9.2	7.5
4	9.2	7.5
5	8.8	8.2
6	10.6	8.7
7	8.5	9.0
8	10.2	10.1
9	12.3	14.7
10	16.6	21.5
Total	100	100

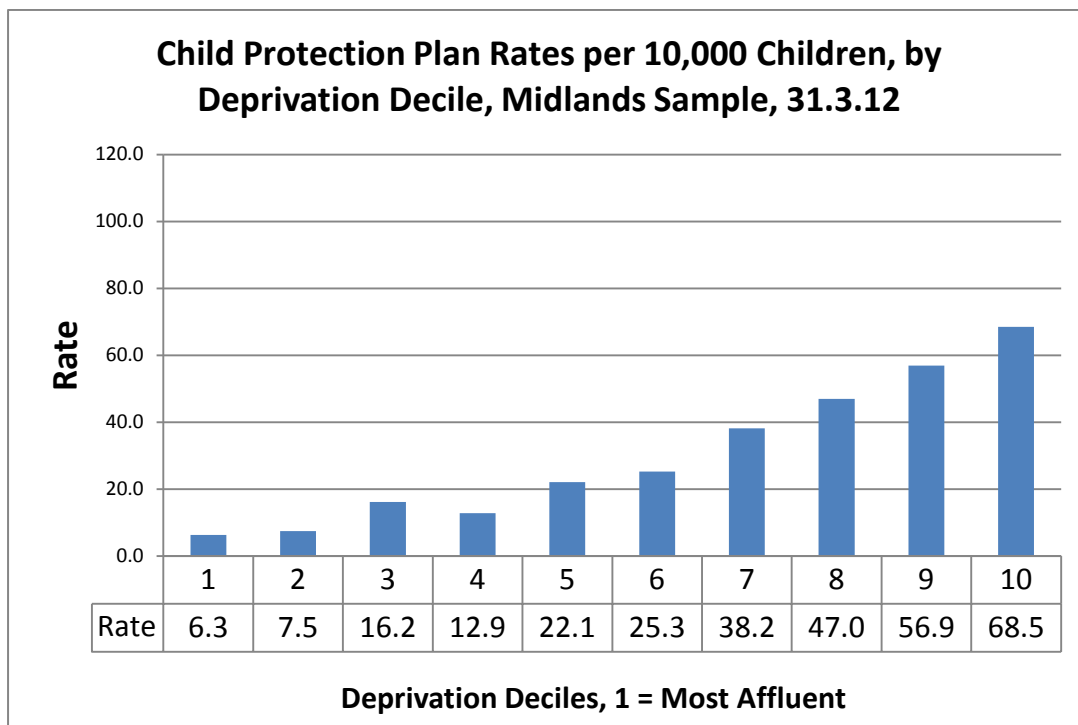
**Chart 1**



**Chart 2**



**Chart 3**



**Chart 4**

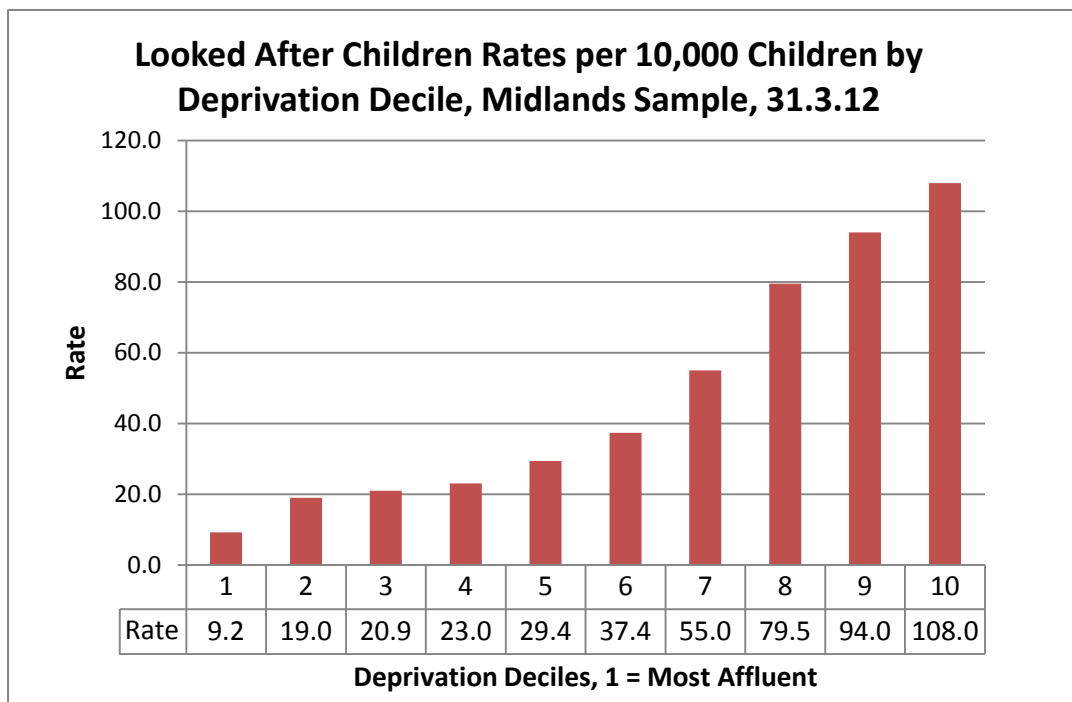


Chart 5

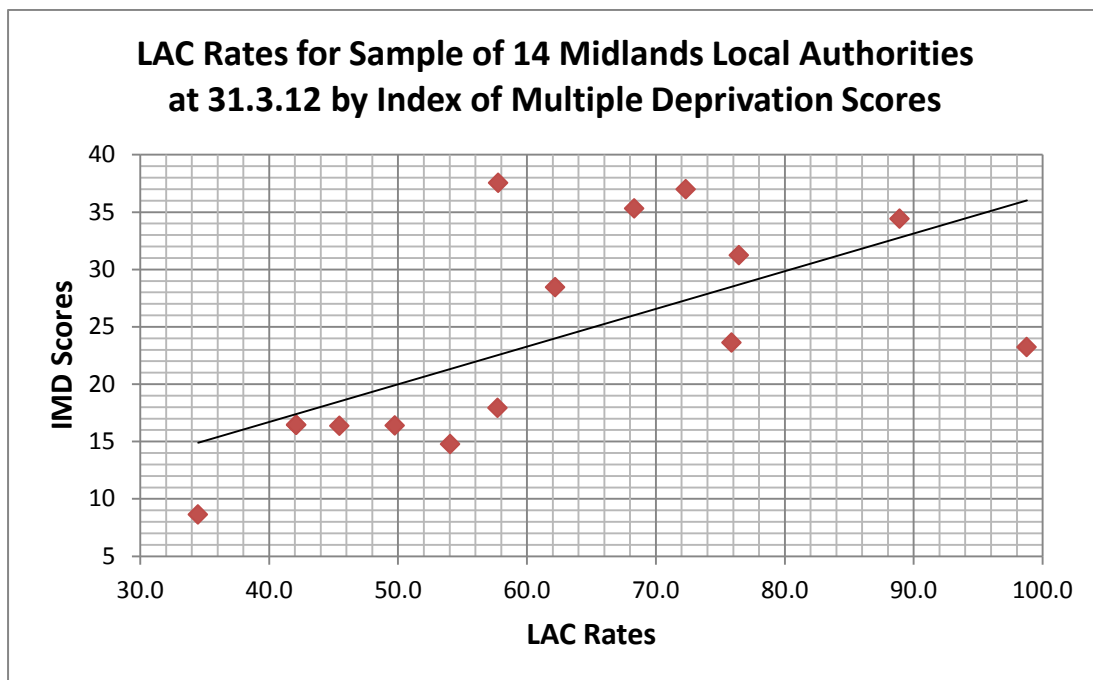


Chart 6

